

WELCOME TO OUR PRACTICE

We Strive to Give Our Patients the Best Quality of Care. We Feel That Your Personal Comfort and Dental Health Are Very Important. We Use Some of the Newest and Safest Techniques in Our Treatments. Please Feel Free To Ask Questions and Let Us Know of Any Concerns You May Have Prior To Treatment.

PATIENT INFORMATION:

Name _____ Title (i.e. Mr. Mrs. Ms.
Etc) _____
Date of Birth _____ Social Security # _____
Home Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
E-Mail _____
Drivers License # _____ State Issued _____ Exp Date _____
Check any that Apply: Minor Single Married Divorced Widowed
Separated
Spouse's Name _____

Employer _____ Position _____
Work Phone _____
Business Address _____ City _____ State _____ Zip _____

Whom May We Thank For Referring You? _____
Person To Contact in Case of Emergency _____ Phone _____

We send email and text reminders for appointments.

Please let us know if you would prefer not to be contacted by either of these methods.

DENTAL HISTORY:

Reason For Today's Visit _____
Previous Dentist _____ Phone _____
Address _____ City _____ State _____ Zip _____
Date of Last Exam _____ Date of Last Dental X-rays _____

Check all That Apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Clicking or popping in Jaw |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Food Impaction | <input type="checkbox"/> Grinding of Teeth |
| <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Broken Fillings | <input type="checkbox"/> Periodontal Treatment |
| <input type="checkbox"/> Orthodontic Treatment | <input type="checkbox"/> Cold Sensitivity | <input type="checkbox"/> Hot Sensitivity |
| <input type="checkbox"/> Sweet Sensitivity | <input type="checkbox"/> Sensitivity When Biting | <input type="checkbox"/> Ear Pain |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Injuries to Head or Mouth | <input type="checkbox"/> Previous use of Gas/Nitrous |

How Often do You Floss _____ How Often Do You Brush _____

Have you ever been diagnosed with oral cancer? Yes No

Has anyone in your family been diagnosed with Oral Cancer? Yes No

MEDICAL HISTORY:

Physicians Name _____ Date of Last Visit _____

Have you had any serious illnesses Yes No

If yes, please describe _____

(Women): Are you pregnant? Yes No Nursing? Yes No

Taking Birth Control Pills? Yes No If so, What? _____

Have you had any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Auto Immune Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nutritional Disorders |
| <input type="checkbox"/> Anemia - Iron Deficiency | <input type="checkbox"/> Fainting Spells/Seizures | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> HIV +/-AIDS | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | |

Are you currently taking any medications? Yes No

- | | | |
|---|---|---|
| <input type="checkbox"/> Antibiotic | <input type="checkbox"/> Aspirin (daily) | <input type="checkbox"/> Anticoagulants: blood thinners |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Heart Medication | <input type="checkbox"/> Anti-Depressants |
| <input type="checkbox"/> Cortisone (steroids) | <input type="checkbox"/> Other | |

If you have checked any of these boxes, please describe: _____

Are you allergic or have you had any adverse reactions to:

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Other Antibiotics |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | |
| <input type="checkbox"/> Other: Please Describe: _____ | | |

PLEASE READ

APPOINTMENTS: A fee of \$50 will be incurred for failed or canceled appointments without prior 48-hour notification. Once an appointment has been made, this time has been reserved for you.

INSURANCE: To avoid any misunderstanding regarding insurance, we wish our patients to know that all professional services rendered are charged directly to the patient, and the patient is personally responsible for payment of fees. In order to facilitate this, we would be happy to discuss financial arrangements prior to treatment so that our patients may conveniently pace

their payments. We will prepare any necessary forms or reports to help you obtain benefits from insurance companies, upon receipt of full (or partial) payment of your bill.

**For Your Convenience, We Accept
Cash ♦ Checks ♦ Visa ♦ MasterCard ♦ American Express**

SIGNATURE _____ DATE _____

Please notify us of any changes of employment, address, and phone number or medical status.

Dental and Medical History Reviewed Orally with Patient

Clinician Name _____ Date _____

Clinician Signature _____ Date _____